TOTAL ORTHOPEDICS
SPORTS & SPINE

Methodist
MEDICAL GROUP

Welcome Information

Thank you for choosing Total Orthopedics Sports & Spine (TOSS) to take care of your health care needs! We know that you have a choice in selecting your medical care and we strive to provide you with the best service possible. Here are a few of our office policies.

Registration: All patients must complete a patient information form before seeing their provider.

Appointment Requirements:

- Please bring your Driver's License/Government- Issued ID and Insurance Card (if applicable) to your visit.
- Arrive 30 minutes prior to your scheduled appointment time.
- Assist our Physicians by bringing your Radiologist Report in addition to any MRI, CT, or scans you may have had done.

MyChart: You will be given a login to access our Patient Portal. This will assist you with timely access to a summary of your visit, secure messaging to email your Provider a question, and for you to update your address and contact information.

Charges: Full payment is due at the time services are rendered unless other payment arrangements have been made. For patients without insurance, payment is due at the time of service for both sick and well visits. Copays and balances are expected at the time of service. After 90 days, outstanding balances will be referred to a collection process**. In the event your health plan determines a service to be "non-covered", you will be responsible for all non-covered and allowable charges.** Delays in insurance processing occur when insurance information is not provided in a timely manner. Such delays may also result in insurance not covering care. Whenever insurance denies payment for a service, it is your responsibility to cover the charges, therefore, it is important to review your benefits with your insurance provider.

FMLA/ Paperwork:
Any patient that needs paperwork completed by Methodist Medical Group/Total Orthopedics Sports & Spine may be assessed a processing fee. This must be paid in full before the paperwork can be picked up or faxed. Please inquire with our staff regarding specific fees prior to submission of your form(s).

NSF/ Closed Accounts: There will be a $35.00 charge added for returned checks.

Medical Records Request: There is a $25.00 fee for medical records up to 25 pages. Additional pages are $0.50 per page. All Medical Records are processed by HealthMark and take seven business days to process.

Appointments/ No Show: We request 24-hour notice for appointment cancellations. Patients with three (3) missed appointments and/ or no shows annually will result in dismissal from the practice. If you no show to your appointment you may be charged $25.00. These charges are not payable by your insurance company. You will be required to pay this charge before your next scheduled visit.

Insurance: Insurance cards must be available prior to each visit. Please notify our office if there is a change in your insurance plans or coverage. We file claims as a courtesy to our patients and are only responsible for filing claims to the contracted insurance company for the member. Any dispute for unpaid charges from the insurance company will be billed to the member. Please be advised that we are a part of Methodist Medical Group, therefore any statements will be sent to you by Methodist Medical Group. All patients must have a valid insurance ID card in order to utilize benefits.

Medication Refills: All prescription refill requests should be called into your pharmacy at least five (5) working days before the last pill taken to allow adequate time for approval. Refills will only be handled during normal business hours, Monday through Friday. Narcotic prescriptions will not be refilled after office hours or on weekends.

Referrals: Allow 5 to 7 working days to process routine referrals.

Behavior: Physical and verbal abuse towards the office staff or other patients will not be tolerated. This includes disruptions affecting daily operations within the office as well as offensive behavior on the telephone with office personnel. Abusive behavior towards personnel will result in immediate dismissal from the practice.

After Hours: Our phone message will direct patients to our answering service for urgent needs after hours. The answering service will notify the physician on call.

Feedback: We appreciate all feedback provided. You will be receiving a patient satisfaction survey from Press Ganey. Please take time to complete this and let us know how we are doing.

Thank you for your understanding and agreeing to our Office Policies. We are committed to be an involved member of your Health Care Team working together for your health!

Signature of Patient or Guardian

Patient Date of Birth

Relationship to Patient, if not signed by the Patient

Date

TOTAL ORTHOPEDICS
SPORTS & SPINE

Patient Information

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Patient Name: _____ _____
First MI Last Preferred Name

SS#:_____ Birth Date:_____ Age:_____ Height:_____ Weight:_____ Sex: Male ☐ Female ☐

Address:_____
Street Address Apt. # City State Zip

Patient lives in: ☐ Home ☐ Apartment ☐ Nursing Home ☐ Name of Nursing Home Ph: _____

Cell #:_____ Work #:_____ Home #: _____

Email Address: _____ Driver's License #: _____

Patient's Employer:_____ Address, City, Zip: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

Work Status: ☐ Working Full-time ☐ Working Part-time ☐ Retired ☐ Student ☐ Disabled ☐ On Leave
Occupation:_____ Employer: _____

Guardian Information (If patient is a Minor/under the age of 18)

Name:_____ Relationship to Patient: _____

SS#:_____ Birth Date:____/_____/_____ Age:_____ Height:_____ Weight:_____ Sex: Male ☐ Female ☐

Address:_____
Street Address Apt. # City State Zip

Cell #:_____ Work #:_____ Home #: _____

Email Address: _____ Driver's License #: _____

Primary Care Physician:_____ Phone: _____

Section I. Primary Insurance (If you do not have insurance, please skip to Section II.)

Policyholder's Employer:_____ Policyholder's Name: _____

Policy #:_____ Group#:_____ Policyholder's Date of Birth:_____

Patient's relationship to Policyholder: ☐ Self ☐ Spouse ☐ Legal Guardian ☐ Dependent ☐ Other: _____

Secondary Insurance

Policyholder's Employer:_____ Policyholder's Name: _____

Policy #:_____ Group#:_____ Policyholder's Date of Birth:_____

Patient's relationship to Policyholder: ☐ Self ☐ Spouse ☐ Legal Guardian ☐ Dependent ☐ Other: _____

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Name:_____ Date:_____ DOB:_____

Date of Injury:_____ Referred by: _____

Family Physician:_____ Phone: _____

Details of Injury: (How? Where? Any Treatment?) _____

_____

Body part being seen for: _____

Side of body: (check) ☐ Right ☐ Left ☐ Both Dominant Hand (check): ☐ Left ☐ Right

Date symptoms began:_____/_____/_____ Current Symptoms: _____

If there is pain, where is it located?_____ Pain Level (1-10; 10 being worst): _____

Medical History (High Blood Pressure, Diabetes, Emphysema, Gastric Reflux, etc.) _____

_____

_____

Patient Medications:_____

_____

_____ ☐ See Attached List

Pharmacy:_____ Address:_____

HOSPITALIZATIONS/SURGERIES	YEAR	SURGEON/HOSPITAL

Patient Drug Allergies: _____

_____

_____ ☐ No Known Allergies

FAMILY HISTORY						
Member	Alive/Deceased				Age	Heath Status
Grandmother(mom's)		A		D		
Grandfather (mom's)		A		D		
Grandmother (dad's)		A		D		
Grandfather(dad's)		A		D		
Father		A		D		

FAMILY HISTORY						
Member	Alive/Deceased				Age	Heath Status
Mother		A		D		
Sister/Brother		A		D		
Sister/Brother		A		D		
Sister/Brother		A		D		
Sister/Brother		A		D		

Review of systems (please check if you are currently or have had problems with these and describe)

❒ Fevers ❒ Chills ❒ Night Sweats ❒ Lethargy ❒ Weight gain or loss of 10 pounds in the last 12 months ❒ Depression
❒ Anxiety ❒ Hallucinations ❒ Eye pain ❒ Change in Vision ❒ Earache ❒ Ear drainage ❒ Nasal drainage ❒ Throat Pain
❒ Change in voice ❒ Chest Pain ❒ Irregular Heart beat ❒ Stroke ❒ Shortness of breath while lying flat
❒ Shortness of breath ❒ Wheezing ❒ Oxygen usage at home ❒ Abdominal pain ❒ Nausea ❒ Jaundice ❒ Ulcers
❒ Constipation ❒ Diarrhea ❒ Vomiting ❒ Painful Urination ❒ Blood in urine ❒ Flank pain ❒ Urinary incontinence
❒ Numbness in genital area ❒ Neuropathy ❒ Seizures ❒ Focal weakness ❒ Focal numbness ❒ Sciatica
❒ Balance problems ❒ Diabetes ❒ Excessive thirst ❒ Cold intolerance ❒ Heat intolerance ❒ Cancer ❒ Tuberculosis
❒ Blood clot ❒ Arthritis ❒ Hepatitis ❒ High Blood Pressure ❒ Skin issues: _____ ❒ Hay fever/Allergies
Other:_____

Social History

Do you drink alcohol? ☐ No alcohol consumption ☐ Yes, consumes alcohol ☐ Social Drinker ☐ Previous Alcoholism

Do you use tobacco? ☐ Never ☐ Currently (everyday) ☐ Currently (some days) ☐ Formerly

Do you overuse/abuse? ☐ Never ☐ Currently ☐ In the past

Exercise regularly? ☐ Yes ☐ No Times per week and type:_____

Do you use an assistive device for ambulation (cane, walker, etc.)? ☐ Yes ☐ No Type:_____

Patient/Legal Guardian Signature: _____ Relationship to Patient:_____ Date:_____

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We are required by law to ask and update your medical record. Please complete the information below. (PLEASE PRINT ALL INFORMATION)

Primary Language (Check One)

☐ English ☐ Spanish ☐ Other: _____

☐ Decline to Answer

Ethnicity (Check One)

☐ Not Hispanic or Latino ☐ Hispanic or Latino

☐ Decline to Answer

Race (Check One)

☐ White ☐ Black / African American ☐ Asian ☐ Hispanic / Latino ☐ American Indian or Alaskan Native

☐ Native Hawaiian or other Pacific Islander ☐ Other: _____ ☐ Decline to Answer

Religion (Check One)

☐ Baptist ☐ Catholic ☐ Christian ☐ Non -Denominational ☐ Other: _____

☐ Decline to Answer

How Did You Hear About Us?

☐ Online Appointment Request ☐ High School Affiliation

☐ Physician Referral ☐ Professional - College Sports Affiliation

☐ Urgent - Acute Care ☐ Magazine - Newspaper - Print Ad

☐ Hospital ER ☐ Insurance Carrier Referral

☐ Internal Referral ☐ Workers Compensation

☐ Internet Search ☐ Friends - Family - Word of Mouth

☐ Social Media ☐ Other: _____

Was there an injury? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No Car Accident? ☐ Yes ☐ No

Sports Related? ☐ Yes ☐ No

Attorney Involved? ☐ Yes ☐ No

I understand and agree that I am responsible for all services rendered in the event this is work related and my claim is denied when filed to worker's compensation. I understand that Methodist Medical Group/Total Orthopedic Sports & Spine (TOSS) does not file any third-party insurance for motor vehicle or other accidents.

By signing below, I am verifying that the information provided is complete and accurate.

_____ _____

Signature of Patient / Legal Guardian Relationship to Patient

_____ _____

Printed Name Date

NOTICE TO PATIENTS

DISCLOSURE OF PHYSICIAN OWNERSHIP

To better serve you, some of the physicians at Total Orthopedics Sports & Spine (TOSS) have ownership interests in various healthcare facilities in North Texas. These facilities and our physicians are committed to providing clinical services to our patients in a safe, high quality environment. Their ownership interest in these facilities often provides them a voice in administration and in clinical and operational policies. This involvement helps ensure the highest level of patient care and customer service.

The following is a current list of facilities (individually a "Facility") with whom one or more Total Orthopedics Sports & Spine (TOSS) have an ownership financial interest:

- Methodist McKinney Hospital, including Methodist Allen Surgery Center
- North Star Diagnostic Imaging

Patients of Total Orthopedics Sports & Spine (TOSS) always have the option of utilizing an alternate health care facility. Total Orthopedics Sports & Spine (TOSS) welcome any questions regarding this aspect of their patient's care.

As nationally recognized leaders in orthopedic care, Total Orthopedics Sports & Spine (TOSS) are at the forefront of advancements designed for patients with orthopedic problems. Total Orthopedics Sports & Spine (TOSS) are frequently sought out by medical device manufacturers and other healthcare companies and organizations (individually, a "Company") to participate in research, development, education and other healthcare initiatives. These organizations realize that physicians are important contributors to the ongoing advancements in healthcare. As such, these companies sometimes offer ownership interests to physicians which is common industry practice. Some of these healthcare companies or organizations may be used in your medical treatment. However, a physician's decision as to which product, device or provider, if any, to be used in your care and treatment is made upon the physician's clinical judgment and what is in your best medical interest.

The following is a current list of companies with whom one or more Total Orthopedics Sports & Spine (TOSS) have ownership relationships. Please feel free to ask your Total Orthopedics Sports & Spine (TOSS) any specific questions or concerns you may have about a company, product or your physician's ownership with Total Orthopedics Sports & Spine (TOSS).

Dendrite Monitoring Services	Sintu	Salutaris Healthcare, LLC

We hope this helps clarify the nature of our ownerships with other healthcare companies and organizations in orthopedic care. We are very proud to be leaders in technological innovation that we believe ultimately results in better patient care.

Please review carefully the information contained in this Notice.

1. During the course of our physician/patient relationship, I may refer you to a Facility or one or more other physicians who provide specialized medical services or refer the use of a Company product, device or provider.

2. I want to inform you that I am aware of the services, devices and/or products provided at a Facility or a Company when I have an ownership interest in it. Further, if I refer you to another physician for specialized medical services, that physician also may have an ownership or financial interest in a Facility or a Company.

3. I am providing this information to help you make an informed decision about your health care. You have the right to choose your health care provider. Therefore, you have the option to use a health care facility other than a Facility (as previously defined) or physicians or a product, device or provider other than from a Company (as previously defined) to whom I might refer you from time to time to.

4. I will not be treating you differently if you choose to obtain health care at a facility other than a Facility and, if you desire, I will be happy to provide you information about alternative health care facilities.

If you have any questions, please do not hesitate to ask. We welcome you as a patient and we value our relationship with you.

By signing below, you acknowledge that you have read and understand this notice, and that you are aware of the ownership interest in a Facility or Company, held by some of the physicians at TOSS. Should you be referred to the Facility or Company, or to another physician at TOSS who holds an ownership interest in the Facility or Company, you acknowledge that as a part of your treatment plan, your physicians may refer you to a facility; or use devices, medications, or products produced by a company that the physician has an ownership interest in. You further acknowledge that you signed this notice prior to the receipt of a referral to the Facility or Company or another physician at TOSS.

Signature of Patient / Legal Guardian, (if applicable)	Relationship to Patient (if not self)
Printed Patient Name	Patient Date of Birth

TOTAL ORTHOPEDICS SPORTS & SPINE

Methodist MEDICAL GROUP

Financial Policy

1. **Authorization to Release Information:**
   I authorize **METHODIST MEDICAL GROUP/ Total Orthopedics Sports and Spine (TOSS)** to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party payer for the purpose of obtaining payment on account of (1) **METHODIST MEDICAL GROUP/TOSS,** (2) any other person(s) or entities financially responsible for the patient's care or treatment, and (3) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases such as Acquired Immune Deficiency Syndrome ("AIDS"). I authorize the release of information from or the review of the patient's records for purposes of conducting medical audits, utilization reviews, or quality assurance reviews.

2. **Assignment of Benefits:**
   We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance at the time of service.

   If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees for costs of collection.

   I understand that I am responsible for providing **METHODIST MEDICAL GROUP/TOSS** all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

   I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to **METHODIST MEDICAL GROUP/TOSS**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that in the event my health plan determines a service to be "non-covered", I will be responsible for all non-covered and allowable charges. I hereby authorize said assignee to release all information necessary to secure payment.

3. **Medicare / Medicaid Assignment of Benefits: (Do not complete unless you receive Medicare/Medicaid health care benefits)**
   a. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

   Initial _____

   b. I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount, duration and/or scope of the Texas Medicaid Program, as determined by the Medicaid Department or its health insuring agency. All payments for non-covered services are due and payable at the conclusion of each office visit unless prior payment arrangements have been made.

   Initial _____

_____ _____
Signature of Patient or Guardian (and relationship if not patient) Date

_____ [ ] Patient under 18 years of age
Witness

_____ _____
Translator (Print Name) Translator (Signature)

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General Patient Consent for Care

General Consent to Care:
I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Methodist Medical Group (MMG)/Total Orthopedic Sports & Spine (TOSS) on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Total Orthopedic Sports & Spine (TOSS) is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Total Orthopedic Sports & Spine (TOSS).

Telemedicine
I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

To the Patient:
You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

Signed Consent

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

I hereby give my consent to treat minor child/children below, which is under the legal age of eighteen years of age, to receive medical care and/or treatment from the providers of Methodist Medical Group (MMG)/Total Orthopedic Sports & Spine (TOSS). Any care deemed medically necessary may be provided with **or** without my presence:

Child: _____ Date of birth _____

Child: _____ Date of birth _____

Child: _____ Date of birth _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ [ ] *Patient under 18 years of age*
Signature of Patient or Legal Guardian

_____
Date

_____
Printed Name of Patient or Legal Guardian

_____
Relationship to Patient

This consent to medical treatment will expire 12 months from the date signed, or until revoked in writing

Patient Preference Regarding Communication of Health Information

In order to better protect your privacy under HIPAA, we have created this consent form for releasing medical information to family members and other people of your choosing. This will also be used for consent to leave you detailed telephone messages at the phone numbers listed below, mail your lab results to your home and also send secure email results to your personal email address once enrolled in MyChart. We are legally not allowed to release medical information to patient family members without the patient's written consent. The purpose of this document is to protect your privacy.

Communication to Family Members, Spouses or Other:

I authorize Methodist Medical Group (MMG)/ Total Orthopedics Sports & Spine (TOSS) and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Emergency Contact Only: Name: _____ Relation: _____ Phone: _____

Communication for Appointment Reminders and Appointment Follow-Ups:

Methodist Medical Group (MMG)/ Total Orthopedics Sports & Spine (TOSS) may need to use your name, phone number, email address ("Contact Information"), and your clinical records to contact you with appointment reminders and information about treatment alternatives. If this communication is made by phone and you are not available, a message will be left on your voice mail or with the person answering the phone. By signing this form, you are consenting for Total Orthopedics Sports & Spine to contact you with appointment reminders and information and to leave messages on a voice mail or with individuals at you home. Information that we use or disclose based on this consent may be subject to re-disclosure by anyone who has access to the reminder and my no longer be protected by federal privacy rules.

You have the right to refuse to give Methodist Medical Group (MMG)/ Total Orthopedics Sports & Spine (TOSS) your consent to use your telephone number and/or email address for appointment reminders and treatment alternatives. If you chose to give your consent, you have the right to revoke it, in writing, at any time in the future. If you refuse to give Total Orthopedics Sports & Spine this consent or revoke it in the future, it will not affect the treatment we provide to you.

I CONSENT to the following forms of communication for appointment reminders and follow-up communication (*please initial all that apply*): ____ email address _____ phone number _____ text message[1] _____ secure patient portal to be used in the manner described above.
Preferred Email Address _____ Preferred Telephone Number _____

If you consented to communication via the secure patient portal, you will be notified via email when there is secure information for you to review such as lab results. The email will provide a link that you will use to access the secure website. After clicking on the link, you will be required to log-in and provide your unique user name and password.

In choosing your email address, please consider privacy implications; for example, any other person that may have access to your email or any other person, such as your employer, that may have the right and/ or ability to review all email received at your work address.

____ (initial) I decline to give Methodist Medical Group (MMG)/ Total Orthopedics Sports & Spine (TOSS) consent to use my Contact Information and clinical records to contact me with appointment reminders and information about treatment alternatives. I understand I may be required to schedule a follow up appointment with the doctor for review my test results or it could take up to 10 business days to receive your results in the mail.

Consent and Agreement: I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for the communication of my health information.

_____ _____

Signature of Patient or Guardian Date

[1] Please note the text messaging service is a complimentary service provided by TOSS, but standard messaging rates from your wireless carrier may still apply. If you have questions, please contact your wireless carrier.

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Notice of Privacy Acknowledgement

Methodist Medical Group Notice of Privacy Practices provides information about how *Methodist Medical Group (MMG)/Total Orthopedics Sports & Spine (TOSS)* may use and disclose your protected health information. You have the right to review the Notice before signing this acknowledgment. A copy of the current Notice is posted in the waiting room. The Notice contains the effective date and as provided in our Notice, the terms of our Notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for **treatment, payment and health care operations**, as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures on your prior consent.

This Privacy Acknowledgement does **not** give us consent to release records to anyone except to whom is mentioned. A signed medical release authorization form must be completed prior to us releasing records on your behalf.

Thank you for your understanding and agreeing to our Office Policies. We are committed to be an involved member of your Health Care Team working together for your health!

Signature of Patient or Guardian

Patient Date of Birth

Relationship to Patient, if not signed by the Patient

Date